



BRIDGING CULTURES & ENHANCING MANAGED CARE

Isored by



U.S. Department of Health and Human Services
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Bridging Cultures & Enhancing Care:
Approaches to Cultural & Linguistic Competency in
Managed Care

May 30, 2002

Chicago, Illinois

Sponsored by:

HRSA

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This conference summary reflects the information provided by and the opinion of the conference presenters/participants and is not that of the American Public Human Services Association, the Health Resources and Services Administration, or the U.S. Department of Health and Human Services.

Dear Colleague:

The Health Resources and Services Administration (HRSA) is pleased to share with you the enclosed publication entitled, "Bridging Cultures and Enhancing Care: Approaches to Cultural and Linguistic Competency in Managed Care." This publication highlights the events of a national conference that was sponsored by the HRSA Center for Health Services Financing and Managed Care in cooperation with the American Public Human Services Association (APHSA). This conference program covered the core information that will enable participants to define and assess the cultural and linguistic competency of their organization and provider network.

Hopefully, this publication will serve as a valuable resource as your organization moves toward becoming more culturally competent. Copies of this publication may be downloaded from the HRSA Center for Health Services Financing and Managed Care's website at www.hrsa.gov/financeMC or ordered from:

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INTRODUCTION

On May 30, 2002, representatives from State Medicaid agencies, managed care organizations (MCOs), state and local health departments, Ryan White CARE Act HIV/AIDS providers, public hospitals, family support groups, state mental health agencies, and others convened in Chicago, Illinois for a conference to discuss the special issues related to providing culturally competent healthcare for patients with diverse cultural backgrounds. The one-day conference "Bridging Cultures & Enhancing Care: Approaches to Cultural & Linguistic Competency in Managed Care" was sponsored by the Health Resources and Services Administration (HRSA) Center for Health Services Financing and Managed Care in cooperation with the American Public Human Services Association (APHSA).

The conference began with opening remarks from Gregory A. Vadner, Director, Division of Medical Services for the Missouri Department of Social Services in Jefferson City, Missouri. After general introductions and administrative announcements, the objectives for the meeting were set forth.

Conference Goals and Objectives

Program Goal:

To motivate and increase the ability of participants to enhance the cultural and linguistic competence within their managed care organization and their provider network(s).

Program Objectives:

Program participants will gain an understanding of:

- The contribution of cultural and linguistic competence to improved health outcomes
- The business and clinical perspectives for developing culturally and linguistically appropriate organizations and services
- The contribution of culturally and linguistically appropriate services to clinical practice and health outcomes through improved provider/patient communication, adherence, early diagnosis, and improved prevention.
- Developing and implementing culturally and linguistically appropriate organizations and services
- The fundamental elements of culturally and linguistically appropriate organizations and services
- Policies, programs, and services which have been developed by managed care organizations and/or their provider networks in support of cultural and linguistic competency for adaptation and/or incorporation
- How to implement strategies used to develop cultural and linguistic competence in the delivery of healthcare services

CULTURAL COMPETENCY: The Basics

The essential elements of cultural competency were commented on throughout the program by all speakers. Felicia Batts and Josepha Campinha-Bacote** provided comprehensive information about the fundamental aspects of cultural competency. Here, Drs. Batts' and Campinha-Bacote's comments have been synthesized and summarized in a simple format as a foundation for the remainder of this report. "*" and "**" indicate which speaker provided the information.*

What is Cultural Competency?*

There are as many definitions of cultural competency as there are diverse perspectives, interests and needs. However, the following is a broad, generally accepted definition:

A set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals and enable that system, agency or those professionals, to work effectively in cross-cultural situations.*

Cultural competency is based upon the concept that cultural differences extend beyond race and ethnicity. Cultural variations include*:

- race
- country of origin
- native language
- social class
- religion
- mental or physical abilities
- heritage
- acculturation
- age
- gender
- sexual orientation
- other characteristics that may result in a different perspective or decision-making process

Where does Cultural Competency in healthcare begin?*

Cultural competency occurs in both **clinical and non-clinical** arenas.

In the clinical arena, cultural competency is based on the **patient-provider interaction**.

In the non-clinical arena, **organizational policies and interactions** impact the delivery of culturally competent services.

Why is cultural competency important?

When health care services are delivered without regard for cultural differences, patients are at risk for sub-optimal care. Patients may be unable or unwilling to communicate their healthcare needs in a culturally insensitive environment, reducing the effectiveness of the healthcare process. Understanding the fundamental elements of culturally and linguistically appropriate services is necessary when striving for cultural competency in healthcare delivery.

Four Rationales for Cultural Competency in Healthcare Delivery**

1. To respond to demographic changes.
2. To eliminate disparities in the health status of people of diverse racial, ethnic, and cultural backgrounds, especially in particular medical conditions: cancer, cardiovascular disease, infant mortality, diabetes, HIV/AIDS, and child and adult immunizations.
3. To improve the quality of healthcare services and health outcomes.
4. To gain a competitive edge in the healthcare market and decrease the likelihood of liability/malpractice claims. Healthcare is a business, and as such is influenced by the same force driving all big businesses today, including market competition, consumerism, organization restructuring, information service technology, and customized care.

What are some obstacles to culturally competent care?*

- Stereotypes, Biases and Assumptions
- Viewing Culture as 'Them', Not Me
- Confounding Race, Culture and Ethnicity
- Differing Health Belief Models
- Patient Exploitation and Oppression
- Pseudo-explanatory Models
- Cultural Mismatches
- Language and Communications Barriers
- Misdiagnosing Ethnic-specific Medical Concerns
- Cultural Clashes

What are the Pros and Cons of Cultural-Specific Information?*

Cultural-specific information is one aspect of cultural competency that is important but controversial. It can be useful, but misused as well.

Benefits of Cultural-Specific Information*

- Can illustrate important differences among cultures
- Serves as a starting point for cultural assessment of patients
- Opens mind to alternative viewpoints and treatments
- Helps avoid egregious errors

Cautions Regarding Cultural-Specific Information*

- Tends to promote stereotyping
- May fail to fully recognize diversity within groups
- Sometimes creates cultural value scale
- Can give providers false sense of confidence

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The Effects of Race and Ethnicity on the Delivery of Quality Health Care

Nathan Stinson, M.D.

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Nathan Stinson, Jr., PhD, MD, MPH began the presentations by providing a broad and comprehensive overview of how race and ethnicity affect healthcare delivery nationwide. As our country grows increasingly diverse, health disparities based on race and ethnicity are becoming more readily apparent. In 1985, The Task Force Report on Black and Minority Health reported that minorities have comparatively poor health, that health disparities have worsened and that minorities are chronically underserved by the healthcare system.

Racial and ethnic disparities remain even after adjustment for socioeconomic differences.

The March 2002 report “Racial and Ethnic Disparities in Healthcare” issued by the Institute of Medicine (IOM) indicates that these issues have shown little improvement in the past 17 years. The most relevant new finding from the IOM may be that racial and ethnic disparities remain even after adjustment for socioeconomic differences and other healthcare access related factors. The IOM concluded that racial and ethnic disparities in healthcare exist and are associated with worse outcomes in many cases. Further, these disparities in healthcare occur in the context of broader historic and contemporary social and economic inequality, and reflect evidence of persistent racial and ethnic discrimination in many sectors of American life. **The IOM recommended several actions to address healthcare disparities:**

1. **Increase awareness of racial and ethnic disparities in healthcare among the general public and key stakeholders;**
2. **Increase healthcare provider’s awareness of disparities;**
3. **Initiate legal, regulatory, and policy interventions to enact change.**

The IOM report also called for data collection and monitoring according to ethnic and racial backgrounds for myriad purposes (see box).

Why Collect Racial and Ethnic Healthcare Data?

- Evaluate and monitor effectiveness of programs
- Understand etiologic process and identify differences in performance within a plan
- Design targeted quality improvement activities
- Develop cost-effective improvement efforts
- Identify the need for and deploy resources for the provision of culturally and linguistically appropriate services
- Monitor trends over time at local, state, and national levels
- Help all parties understand the scope of the problem of health disparities affecting their clients and stimulate action
- Empower consumers to make informed decisions about health plan choice
- Assure civil rights

However, collecting racial and ethnic information gives rise to some practical and ethical issues. There are perceived legal impediments with respect to confidentiality and privacy and the potential misuse of data. Further, the cost of large-scale data collection is substantial.

In an effort to address the issues of collecting racial and ethnic information, a meeting was jointly held in June 1999 by the Office of Public Health and Science, The Commonwealth Fund, the Agency for Healthcare Research and Quality (AHRQ) and numerous managed care organizations (MCOs). None of the MCOs in attendance routinely collected racial and ethnic information; however, some have obtained such data from research, state Medicaid programs or linkages to other databases (e.g, cancer registries, birth certificates). While MCOs expressed concerns, the general consensus was that if data were to be collected, all plans and health insurers should do it.

With the assistance of the National Health Law Program, Inc. (NHeLP), a review of state and Federal laws was initiated to identify laws and regulations that require or prohibit the collection of racial and ethnic data by health insurers and MCOs. Two Federal health services programs require racial and ethnic data collection and/or reporting: the End-

Stage Renal Disease Program and Substance Abuse and Mental Health Services

Administration (SAMHSA) applications for prevention service activities. Data collection requirements for Medicaid managed care and SCHIP regulations have recently been finalized. Several public program statutes also require racial and ethnic data for participation.

Title VI provides a legal foundation for the collection of racial and ethnic data.

Even when a specific statutory requirement does not exist, Title VI of the Civil Rights Act of 1964 provides a legal foundation for the collection of racial and ethnic data, though it does not specifically mandate or prohibit such data gathering. This Act protects individuals by prohibiting discrimination on the basis of race or national origin in the provision of any services that are supported with Federal funds. Title VI protection extends to all programs and activities of any entity receiving Federal funds, whether or not the particular program has itself received or benefited from those funds. This would therefore include any Medicaid MCOs.

State laws for MCOs and health insurers vary, however. Four states prohibit the collection of racial and ethnic data as part of the application process: California, Maryland, New Hampshire, and New Jersey. Although MCOs are free to collect data at the point of care or at some other time after members enroll, it is logistically more challenging to generate aggregate data this way. Conversely, one state—South Carolina—requires MCOs and insurers to collect racial and ethnic data, while another—Texas—requires collection of primary language information.


After identifying the problem of disparity in healthcare, Dr. Stinson continued to lay the foundation for the rest of the day's discussions by defining cultural competency, a concept viewed by many as the solution to healthcare inequity. According to Dr. Stinson, cultural competency is "the ability of health organizations and practitioners to recognize the cultural beliefs, attitudes and health practices of diverse populations and to apply that knowledge in every intervention—at the systems level or at the individual level—to produce a positive health outcome." He suggests that culturally competent care has the potential to improve access to services, reduce medical errors, and increase the use of preventive services. Furthermore, cultural competency may improve patient compliance

and patient satisfaction, reduce financial costs and liability and ultimately facilitate the elimination of health disparities. In closing, Dr. Stinson explained that the Office of Minority Health has established 14 national standards to inform, guide, and facilitate culturally and linguistically appropriate healthcare services (CLAS). He ended with an apt quote from Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care, a report from the National Academies' Institute of Medicine: "The real challenge lies not in debating whether disparities exist, but in developing and implementing strategies to reduce and eliminate them. Confronting such 'unequal treatment' will require a broad and sustained commitment from those who provide care, as well as those who receive it."

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Building Cultural Competence in Organizations: Focus on Promoting and Sustaining Change

Calvin Freeman
President
Calvin Freeman & Associates
Sacramento, California



Organization leaders are in a position to guide culturally competent change.

Calvin Freeman, former Chief of the Office of Multicultural Health and Head of Disaster Medical Preparedness for the State of California, addressed the issue of promoting cultural competence through organizational change. During Mr. Freeman's 25 years of experience in public health, he has found a broad-based, multi-level approach to be effective for several reasons. First, organization leaders are in a position to guide a large group of people through priority and goal setting. Policies that impact many patients can be defined and implemented throughout the organization. Personnel policies and decisions can be guided by organizational change. Even the physical design of facilities, which is often integral to creating a culturally competent setting, can be addressed.

Mr. Freeman discussed **4 main strategies for improving cultural competence by initiating organizational change:**

- 1. Be strategic in your approach to promoting cultural competence.**
- 2. Build an infrastructure for cultural competence.**
- 3. Recognize the importance of people and relationships.**
- 4. Use the management knowledge and tools you use for other issues.**

According to Mr. Freeman, being strategic in an approach to promoting cultural competency begins with accepting a few assumptions. First, organizations do not change easily because multiple staffs, units and functions are involved. Second, large change is built on small steps—we must get away from the idea that everything must be, or even can be, accomplished at once. Finally, even failed attempts at change can be positive, negative, or both depending on what we choose to learn from the attempts. With an understanding of these concepts in place, the first step to promoting cultural competency in a large group is to assess the status quo. Assessment helps to define the context and environment, identify assets and obstacles, and determine readiness to meet patient and community needs. Assessments also send a message to the organization and community of the intent to promote cultural competence. Looking forward, assessments set a baseline for measuring progress.

Another component to strategically promoting cultural competence is increasing readiness for change. Increasing readiness begins by building internal support for the initiative. The support of decision-makers is crucial as they can gradually increase acceptance of implementers and mobilize change agents. Mr. Freeman noted that it is especially important to manage expectations of staff where change is concerned because increasing cultural competency will not happen overnight, and setting expectations too high and too fast may result in negative backlash. Credibility is also important and can be gained if decision-makers are perceived as actively involved in and committed to the same culturally appropriate behaviors they are asking of others in the organization. In addition, garnering external support can improve an organization's ability to affect change. By engaging a wide mix of allies, understanding their motivations for being involved, and encouraging two-way communication, outside groups such as other MCOs, hospitals, and public agencies can contribute strength to organizational efforts.

Building an infrastructure to sustain the cultural competence development process includes five key elements, according to Mr. Freeman: knowledge, a planning committee, a point person, data and resources. As with any large-scale project, identifying objectives and goals with actions and timelines will keep the effort on track. Further, clearly identifying current and future resources will help assess the sustainability of the efforts.

Mr. Freeman noted that while financial resources are an important part of cultural competency improvement, human resources are just as valuable. Members at all levels of the organization need to believe that these efforts are authentic, will promote better delivery of healthcare services and are important to the overall success of the group. Praise and recognition are often the strongest way to gain internal support. Acknowledge those individuals whose devotion to change is exceptional and unwavering; others will likely follow their model. Finally, communicating the strategic plan to the entire organization as it develops so that everyone remains “in-the-loop” will strengthen the process and help avoid internal conflicts or dissent.

Communicating the strategic plan to the entire organization strengthens the cultural competency process.

Cultural Competence and Linguistically Appropriate Services in the Clinical Setting

Felicia Batts, M.P.H.
President
Consulting by Design
Fresno, California

Ms. Batts shared a comprehensive three-part presentation with the group. The first part, “Development of Culturally Competent Services: The Fundamentals” has been summarized in the introductory section of this report to serve as primer of basic principles and concepts. Part Two (*Promoting Cultural Competence in Clinical Practice: The Patient-Provider Interaction*) and Part Three (*Linguistic Services: Translation and Interpretation Issues*) of Ms. Batts’ three-part session focusing on cultural competence in the clinical setting are summarized here.

Promoting Cultural Competence in Clinical Practice: The Patient-Provider Interaction

Patients belonging to minority groups face disparities in accessing and receiving healthcare. Many feel that they have difficulty communicating with their physicians and that they would receive better care if they were of a different race or ethnicity. Ms. Batts explained that healthcare providers have the power to improve healthcare experiences for minority patients through culturally competent interactions that promote the delivery of quality, timely and effective clinical services to patients of diverse backgrounds.

First, there needs to be an understanding of the value differences between the Western approach to medicine and alternative approaches to which many minorities are accustomed. In Western medicine, the concept that an individual determines his or her own health is generally accepted; this supports the preventive medicine approach and low-power distance between patients and providers with a Western medicine mind-set. Patients from other backgrounds often view things quite differently. They may perceive health and illness as a matter of fate, focusing more on the present state of health rather than the future. Frequently, they may believe the physician has the greater power in the relationship and therefore avoid asking questions about their own condition. Depending on their particular culture and past experiences, patients from minority backgrounds may perceive a physician in unique ways.

Unique Patient Perceptions of Physicians

- Healer/Miracle worker
- Expert
- God's worker
- Shaman
- Confidant or friend of the family
- Authority figure or recipient of unquestioned respect
- Pill dispenser
- Last resort for healing
- Someone who inflicts pain
- Partner in making health decisions

More and more, all patients, regardless of background, are using alternative therapies. Acupuncture and other traditional therapies are being proven effective, and the spiritual and mental aspects of disease are receiving more attention now than ever.

Complementary medicine and alternative health practices are common approaches to maintaining wellness and treating illness among patients of diverse backgrounds. One in three people have used these methods; however, nearly two-thirds do not tell their regular physician about the use of complementary medicine. This is a major concern because of potential treatment interactions. In some cultures, patients may view Western medicine as a last resort because they feel it is too potent. Providers should discuss complementary medicine practices with their patients to gain a better understanding of their perspectives and to determine how Western and alternative therapies can be used together to the patient's advantage.

Next, styles of communication may differ among patients from various cultural backgrounds—beyond language differences. Considering all types of communication (e.g., written, spoken and body language; dialects; and slang) is important to patient-provider interactions. Some communication challenges include medical terminology versus common terms, varying literacy levels, the speed of speech, culturally inappropriate words or phrases, multiple dialects, the use and misuse of interpreters and gender-specific terminology. Ms. Batts conveyed that there is no one definitive curriculum on culturally competent communication and that she does not train physicians in culture-specific methods (e.g., how to interact with Hispanic patients versus Korean patients). Instead, she emphasized that those providers who make attempts to learn about and understand cultural backgrounds of their particular community of patients are best equipped to engage in effective culturally competent communications. However, there are some areas of general concern that can be addressed by providers trying to improve their interactions with culturally diverse patients (see table).

Basic Concern	Questions to Help Providers Understand Patients
Names	How are people named? Do given or family names come first? Are titles used? Do names change?
History	Why did the family immigrate here? Where from? What are conditions in the home country? What health problems exist there? What is the work history of the family?
Language	What language or dialect is spoken?
Religion	What are the spiritual beliefs and do they impact daily routines? Are there any medical taboos? How does religion impact care decisions?
Moral Beliefs	What do patients believe about pregnancy, unwanted pregnancy, sexually transmitted diseases or similar conditions? How does this affect care decisions and disclosure to physicians?
Food	What foods are common? Are there any taboo foods? What are the social rules concerning food?
Community	What services are available in the community? Is this a unified or divided community?
Acculturation	How long has the family/individual resided in the US? To what degree has <i>each individual family member</i> adopted American culture?

Understanding patients' family issues also promotes more culturally competent care. The family structure and make-up, such as who lives in the household and who are the decision-makers, can be important when treating patients. Also, a patient's preferred language may be different than that of other family members; likewise the extent of acculturation may differ. It is better to get to know each individual rather than making assumptions about one family member based on familiarity with another. Also, internal

family conflict may impact the care process; therefore, being aware of signs of conflict can also guide providers as they treat multiple members of the same family.

Patient's beliefs may also impact their communication on numerous health-related issues. Culturally-held attitudes affect how patients identify a medical problem requiring professional attention versus self- or home-care. Patients may also perceive certain topics as taboo and feel uncomfortable discussing them, especially if the provider is opposite sex. Describing such a problem to the provider can be challenging for patients. Further, if patients disagree with the provider, cultural attitudes may inhibit them from sharing their concerns.

Perhaps most important is to establish a level of trust with patients. Discrimination occurs when trust is absent from both the patient and provider perspective. Physicians have limited time to spend with patients, and patients may perceive that physicians are driven by profits even if this not actually the case. A basic lack of trust between patients and providers results in a lack of trust in the diagnosis or treatment of the medical problem. Patients may feel they need to do their own research to validate treatment recommendations and be more proactive and aggressive in order to get quality care. Providers need to be aware of trust issues and strive to establish a connection with patients that will allay their fears.

Discrimination occurs when trust is absent from both the patient and provider perspective.

Linguistic Services: Translation and Interpretation Issues

Accessible and appropriate linguistic services are the foundation of culturally competent healthcare. Eliminating confusion and achieving clarity with patients is essential for ensuring effective communication between patients, providers, and healthcare staff. Linguistic services are comprised of four main elements: oral services, interpretation services, written services, and translation services.

There are numerous reasons to provide linguistics and translation services. First, language and cultural differences may result in under-use of necessary services. In addition, inadequate communication gives rise to concerns about malpractice liability. There is also the need to comply with civil rights legislation and pressure from advocacy

groups. Several Federal laws exist to ensure access to language services for all limited English proficient persons. These laws include Title VI of the Civil Rights Act of 1964, the Hill Burton Hospital Survey and Construction Act of 1946, and the Disadvantaged Minority Health Improvement Act of 1990.

There are many options for providing translation services, though the effectiveness of these options varies.

There are many options for providing translation services, though the effectiveness of these options varies. Healthcare facilities with bilingual and bicultural providers and staff are best equipped to provide translational services; next most desirable is the availability of the staff members hired specifically for interpretation services. When interpretation staff members are assigned other, non-translation duties, their job priorities are divided. Thus, while this may be a financial beneficial strategy, it is not the optimal one for patients in most clinical settings. The use of outside interpreters or telephone interpretation may be required, but again is not the preferred method. Finally, last resorts include the use of family members for translation or referring the patient to another facility; neither strategy is in the best interest of the patient or the healthcare organization providing services.

Having bilingual and bicultural staff allows direct communication between staff members and patients, which reduces miscommunication and misunderstanding. However, there is a lack of qualified providers and staff, even for common languages. Further, there is no standardized tool to assess language and cultural skills. Dialects and language differences related to socioeconomic status may still exist, and translating medical terminology in the target language can be a problem. While building a bilingual staff and provider group is not a perfect solution, it is the best practical option for serving patients in a culturally competent manner.

An "Interpretation-Only" staff offers several benefits, as well. These individuals are more likely to be skilled at medical interpretation, having had didactic training in the field. Also, this option also offers flexibility in hiring practices. However, it works best in a setting with high demand for a single language versus one with linguistic diversity of patients. Again, there is a lack of defined standards in this area, and finally, it can be a costly option.

Hiring an interpretation staff person with other duties is a reasonable alternative when the demand is not sufficient to hire someone full-time. Interpreters can be effective as caseworkers or family health workers, roles where communication is essential. However, care must be taken to avoid conflicts between interpretation services and other duties so that staffers are not confused as to work priorities. If the staff person is used only occasionally for interpretation, costs are reduced and there is someone on-site in an emergency. But this is really only a contingency plan, because maintaining accurate lists of employees who speak particular languages is difficult and it may be challenging to locate that person when he or she is needed, especially in larger facilities. This option also bears the greatest potential for job conflicts.

Using outside interpreters can be effective when there is insufficient demand for a full-time staff member. These interpreters can be hired hourly for prescheduled appointments and can supplement on-staff interpreters as needed. Again, the lack of standards is an issue, and hourly rates can be expensive. Further, there is no established relationship with the provider, and outside interpreters may be difficult to access on short notice, so they cannot be used in an emergency.

The use of telephone interpretation services is especially appropriate for emergency situations, or if brief or basic information is needed. But few telephone translators are medical specialists, so they may lack cultural health knowledge. Also, body language and similar communication clues are lost with this method.

Finding the option that works will be individual for each healthcare setting and will depend upon numerous factors. But doing so is crucial because a lack of translational services or poor translational practices can result in major dilemmas, such as cultural misunderstandings, incorrect assessment of patient's language ability, and confidentiality conflicts. The use of family members, especially children, is highly undesirable because of the potential for family conflict or the impact of the information being conveyed.

The use of family members for translation, especially children, is highly undesirable because of the potential for family conflict or the impact of the information being conveyed.

Several new approaches for selecting an interpretation method are now available, thanks to research regarding the impact, effectiveness, and cost-benefits of various strategies. Also, technology has evolved to allow video conferencing translation and computer software has been developed to aid with translation needs.

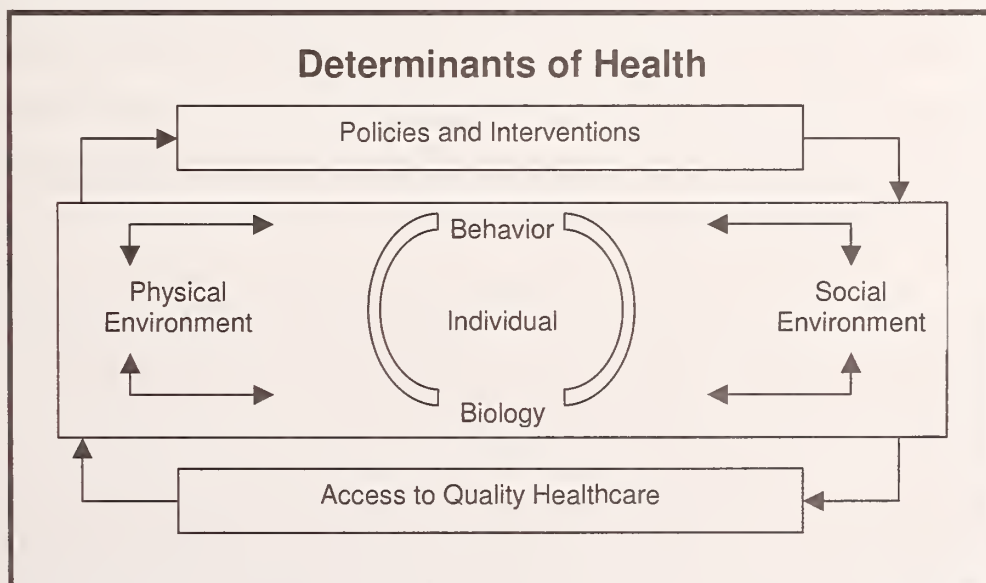
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California's Approach to Ensuring Cultural Competent Healthcare Services in Medicaid Managed Care and SCHIP Health Plans

Gregory A. Franklin, M.H.A.

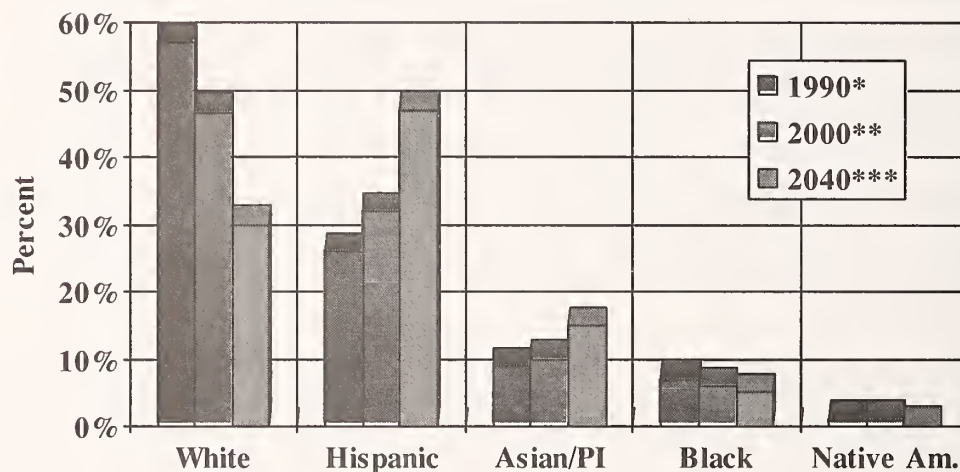
Chief, Office of Multicultural Health
California Department of Health Services
Sacramento, California

Gregory A. Franklin, M.H.A., Chief of the Office of Multicultural Health, discussed how purchasing strategies and the application of policy have provided the foundation for the delivery of culturally and linguistically appropriate healthcare services in Medicaid and State Children's Health Insurance Program (SCHIP) managed care organizations (MCOs) in California. Mr. Franklin began by reviewing the definition of cultural competency (see Introduction), and by discussing a framework for health. Personal health begins with the individual at the center of many other interactive variables (see figure). Policymakers have not only the *ability*, but also the *responsibility* to contribute to this process in a positive manner.



The ethnic and racial composition of Californian residents is rapidly changing; therefore, cultural competency will play a large role in the process of determining health. While the white, African American, and Native American populations are decreasing, the number of Hispanic Americans and Asian or Pacific Islanders is growing simultaneously (see figure).

The Changing Ethnic and Racial Composition of California



* California Department of Finance 1990 Census Data

** US Census Data 2000

*** California Department of Finance Census Projection Data 1990

Medi-Cal, California's Medicaid Managed Care, includes a significant portion of this diverse population. As of April 2002, Medi-Cal enrollment was nearly 2.6 million, of which 45% of members are Latino/Hispanic, 18% African American, and 10% Asian/Pacific Islanders. The Healthy Families Medi-Cal for Children program, SCHIP, includes an additional half-million members with a slightly different ethnic and racial make-up: Latino (66.7%), white (15.9%), Asian Pacific Islander (13.4%), and African American (2.9%). The larger portion of Latino and Hispanic children enrolled through SCHIP reflects the recent growth of this group.

To ensure culturally competent, quality health services are delivered to these members, Medi-Cal has partnered with a range of organizations to enhance care. These groups include:

- Health Advocates
- Hospitals
- Managed Care Organizations
- Community Clinics
- Academia
- Legal Aide Society
- Immigrant Rights Organizations
- State Health Programs
- Provider Organizations

Mr. Franklin noted several important policy considerations that can support efforts to improve healthcare for California residents. First, the concept of “health” itself should be broadly defined in positive terms in order to stimulate proactive, preventive interventions. Secondly, patients and providers need to recognize that the health is determined by sociocultural and economic issues as well as physical factors. And as previously noted, California’s changing demographics will have long term effects on policies that impact healthcare delivery.

With these considerations in mind, Medi-Cal has developed and disseminated numerous policy letters for providers and provider groups in the Medi-Cal network. The policy letters address issues such as linguistic services, translation of written informing material, Community Advisory Committees, and needs assessments. To meet the needs of a culturally and linguistically diverse population, Medi-Cal has identified “threshold languages” (languages common to a significant portion of the patient population) and requires that written material and oral translational services be available in these languages. Members have been informed of these services. Medi-Cal groups have been asked to establish a Community Advisory Committee for recruiting membership and identifying the group’s function. For translation of written informing materials, healthcare groups are required to create linguistically accessible documents and/or timeline for the creation of such materials.

Despite these efforts, some challenges still exist in delivering culturally competent care. There is no “one size fits all solution” for every provider or practice in the Medi-Cal system. Though

Despite these efforts, some challenges still exist in delivering culturally competent care. There is no “one size fits all solution” for every provider or practice in the Medi-Cal system.

enforcement and accountability are important, practical issues sometimes impede required activities. Other obstacles include competing priorities (i.e., the will of health advocates vs. state policy), access issues, and lack of dedicated funding.

Still, the future of quality healthcare depends on continued efforts to overcome these obstacles and bring culturally competent care to every Medi-Cal member throughout the state. Medi-Cal plans to incorporate policies throughout the state health department and make policies and processes available to other state agencies. As they continue to refine existing efforts in managed care, Medi-Cal would also like to develop fee-for-service models for enhancing culturally competent care. Finally, the organization plans to step up its efforts to monitor for compliance with these important policies.

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SUCCESSFUL PRACTICES IN MANAGED CARE

Arizona Health Care Cost Containment System (AHCCCS) Plans and the Provider Pocket Guide

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Georgia G. Hall, PhD, MPH and Philip Nieri, MPA discussed how Arizona's Medicaid program (AHCCCS) developed a cultural competency provider-education initiative in conjunction with its many contracted health plans throughout the state. AHCCCS subcontracts with health plans owned and/or managed by Catholic Healthcare West, CIGNA, United Health Care, Schaller Anderson, Inc. and various hospital based health care companies (e.g. IASIS Healthcare and Vanguard). These companies help manage

services provided to 650,000 members in all Arizona counties. Members choose a plan and PCP to act as their “medical home”.

Because of the many separate entities involved in serving the AHCCCS patient population, the challenge was to create a plan that would improve provider awareness of cultural competency issues across the entire network. By believing that culturally appropriate care improves health outcomes and helps eliminate health disparities, AHCCCS and its subcontractors met that challenge head on. AHCCCS requires its health plans to participate in quality improvement efforts in both clinical and non-clinical areas that would be expected to have a beneficial effect on health outcomes and member satisfaction. One of these areas is cultural competency of services.

AHCCCS, with its subcontractors, established a framework for a cultural competency workgroup to coordinate compliance with cultural competency program requirements, including those imposed federally and by the state. The workgroup helped coordinate the development of annual cultural competency work plans and methods for reporting outcomes from the Cultural Competency Quality Improvement Project. The workgroup includes representatives from all AHCCCS health plans and program contractors from various sectors including compliance, quality management and operations. By engaging in discussions on compliance and by sharing “best-practices” ideas, the workgroup identified a strategy for action. The core idea was to reduce redundancy of culturally competent activities, particularly training and outreach to physicians, and develop new efforts to supplement existing training/outreach resources. A sub-committee was subsequently created by those health plans and programs contractors who volunteered to help.

The sub-committee focused on development of a cultural competency “pocket guide” to be distributed to every provider in an AHCCCS health plan. A consultant was hired to gather information about educational needs in providing culturally competent care and to ensure that information in the guide reflected AHCCCS requirements. The sub-committee also coordinated the printing/distribution of the guide for participating provider offices. Though it required significant coordination between the state and many

individual health plans, the project presented a unique opportunity to jointly develop a useful resource for providers, proving that collaborative projects can work—in spite of competition and other perceived barriers.

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A Culturally Conscious Approach to the Delivery of Healthcare Services

Josepha Campinha-Bacote, PhD, RN, CS, CNS, CTN, FAAN
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Josepha Campinha-Bacote, PhD, RN, CNS, BS, CTN, FAAN, President of Transcultural C.A.R.E. Associates, shared with the group the ASKED model of cultural competence, which she developed and published in 1998. According to Dr. Campinha-Bacote, cultural competency is the “process in which the healthcare provider continuously strives to achieve the ability and availability to effectively work within the cultural context of a client (an individual, family, or community).” Emphasizing the “process” aspect of her model, she states that cultural competence is a journey, not a destination; it is cyclic not linear.

The process of Cultural Competence involves interrelationships between five elements:

Cultural Awareness

Cultural Skill

Cultural Knowledge

Cultural Encounters

Cultural Desires

Hence, the ASKED model.

Cultural awareness requires “self-evaluation of one’s own prejudices and biases towards other cultures. [It is] the process of cultural humility.”¹ It is also a willingness to explore one’s own cultural and ethnic background. Basically, says Campinha-Bacote, cultural awareness means knowing yourself. On a broader level, this concept entails asking the question, “Is there racism in the delivery of healthcare services?” Dr. Campinha-Bacote cited several evidence-based studies that confirm that such racism does in fact exist.

Cultural knowledge includes obtaining a sound educational foundation concerning the various world views of different cultures. Within the field of healthcare, it also means obtaining knowledge of “biocultural ecology”—biological variations, disease and health conditions and variations in drug metabolism related to one’s background. Dr. Campinha-Bacote warns, though, that it is necessary to be wary of intra-ethnic and intra-cultural variations; even within cultural groups, many differences exist.

Cultural skill is the ability to collect culturally relevant data regarding a client’s health history and current medical problem. This is done using a cultural assessment tool. Conducting a culturally-based physical examination is also part of cultural skill in healthcare. These assessments should be conducted in a culturally-sensitive manner. Dr. Campinha-Bacote reminded the audience that *everyone* should be given a cultural assessment. Only conducting an assessment with patients who “look like” they might need one is a culturally bias practice itself. A cultural assessment tool is available in Dr. Campinha-Bacote’s book, The Process of Cultural Competence in the Delivery of Healthcare Services.² The ultimate goal of a cultural assessment is to determine appropriate culturally responsive interventions, which ask providers to recognize the differences in individuals, but build upon similarities to others.

Another element of the process is the *cultural encounter*. Cultural encounters are the process by which healthcare providers directly engage in face-to-face, cross-cultural interactions. The goals of these interactions are to generate a wide variety of verbal

¹ Tervalon, 1998

² Campinha-Bacote, J. “Cultural Skill” in The Process of Cultural Competence in the Delivery of Healthcare Services. 1998, 3rd edition. OH: Transcultural C.A.R.E. Associates.

responses (i.e., encourage patients to communicate openly) and to send and receive both verbal and non-verbal messages accurately and appropriately in each culturally different context.³

Perhaps the most vital component of the ASKED model is *cultural desire*. This, unlike the other four elements, is not

Cultural Desire is not necessarily a learned behavior; rather, it is based upon provider's internal motivation to engage in the Cultural Competency process.

necessarily a learned behavior; rather, it is based upon provider's internal motivation to engage in the cultural competency process—because they *want* to, not because they *have* to. Characteristics of a provider who has cultural desire include compassion, authenticity, humility, openness, availability, and flexibility. Dr. Campinha-Bacote emphasizes that skill, knowledge, and awareness matter very little without desire: “People (i.e., patients) don’t care how much you know until they first know how much you care.”

One application of the ASKED model of cultural competence is the BE SAFE model, a culturally competent model for caring for African Americans with HIV/AIDS. Following Dr. Campinha-Bacote’s presentation, her colleague John McNeil, MD, Principal Investigator for National Minority AETC in Washington, D.C., describe the BE SAFE model.

Model of Cultural Competency for Working with African American Patients Infected With HIV

John McNeil, MD
Principal Investigator
National Minority AETC
Washington, D.C.

John McNeil, MD, Principal Investigator for the National Minority Aids Education Training Center (AETC) in Washington, D.C., discussed cultural competency in a very specific context: caring for African Americans with HIV or AIDS. Dr. McNeil noted that people of African descent who reside in the United States are a hybrid population.

³ Adapted from Sue, 1982

Most African Americans have genetic make-ups that cross African ethnic groups and other racial groups, primarily European and American Caucasian, as well as Native American. Caribbean population mixtures include East Indians, Chinese, and Indigenous West Indians. Nearly one million individuals have emigrated from nations in Africa and the Caribbean since 1994, with Florida, New York and New Jersey being the most highly populated areas. Within the African American community, many cultural differences exist, and recognizing these differences is vital to providing culturally competent healthcare.

Moreover, providing culturally appropriate care for African American patients with HIV requires a unique sensitivity to issues that transcends race or ethnic background. There are shared behaviors and issues that create a culture associated with the disease itself. Patients with HIV/AIDS experience emotional distress, sexual orientation issues, economic hardship, and societal discrimination. They may also participate in high-risk behavior and substance abuse as part of their daily lives. Understanding and addressing these issues is vital to providing culturally competent care.

The National Minority AIDS Education and Training Center developed a model of cultural competency for African American patients with HIV/AIDS. A multidisciplinary panel comprised of physicians, nurses, dentists, physicians' assistants, and HIV educators was organized; the panel included a heterogeneous mix of individuals born in America, the Caribbean, Africa, and Cape Verdean. The primary aims of the panel were to 1) encourage a deeper understanding of cultural competency as it relates to the HIV infected patient, 2) assist clinicians working with HIV-infected patients to develop their understanding of intra-ethnic variations, and 3) develop an understanding of the role HIV plays in values, beliefs, and customs of a patient. These aims were achieved through the development of the model and dissemination of information to care providers.

The result of the panel's efforts was the **BE SAFE** model for culturally competent care for African American patients with HIV/AIDS. The model is based upon the principles of Josepha Campinha-Bacote's model of cultural competency. BE SAFE is an acronym for six major factors that influence the quality of care these patients receive: Barriers, Ethics,

Sensitivity of providers, Assessment, Facts, and Encounters. Providers are encouraged to consider all elements of the model in their daily practice. The BE SAFE model is detailed in the figure below; each list identifies major issues to consider during each step of the BE SAFE process of culturally competent care.

B	E
Barriers	Ethics
Prejudices Socioeconomics Ethnicity Stigma Mistrust Geography	Third Party Notification Responsibilities Desire Humanizing Confidentiality Truth Telling Difficult Patients Dying Patients Professionalism HIV Specific Ethics Patient's Rights

S	A	F	E
Sensitivity	Assessment	Facts	Encounters
Provider Biases Stigmas Self-Exploration Cultural Imposition Unpopular Patients	Physical Emotional Spiritual Social Mental Occupational	Purnell's 12 Domains Values Beliefs Practices/Customs World Views Biocultural Ecology	Encounter Strategies Case Presentations/Studies Language/Communication Do's and Don'ts Establishing Cultural Communication

Enhancing Family-Centered Care in Managed Care Organizations

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Parents Helping Parents, Inc.
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In California, a dramatic population shift is occurring: while the percentage of African Americans remains stable and the proportion of whites decreases, the number of Asian and Hispanic Americans is rapidly rising. Further, the number of recent mixed-race births is also climbing, with more than 70,500 biracial children born in 1997 alone. Healthcare plans and community groups in this increasingly diverse state have thus turned their attention to devising ways of offering more culturally competent care to its members.

Parents Helping Parents (PHP), a parent-directed family resource center, and Kaiser Permanente, a managed care facility, joined forces to create a national model for introducing family-centered, culturally competent services for Children with Special Health Care Needs (CSHCN) into managed care through a collaborative consumer/provider partnership. Sophie Arao-Nguyen, Ph.D., cultural competency consultant and PHP Advisory Board Member, described this exciting and successful initiative.

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In 1994, PHP and Kaiser Permanente received a 4-year SPRANS grant (Special Projects of Regional and National Significance) to develop and assess this model. When children with special needs visited Kaiser Permanente's offices in Santa Clara and Santa Teresa, California, physicians referred parents to PHP as a supportive resource. In turn, PHP hired and trained a parent liaison, working through Kaiser Permanente, to enroll and support parents who sought out their services. PHP services include information and education, mentor parents, support groups by disability and by language, and translation services. In addition, PHP trained Kaiser Permanente physicians, nurses, social workers,

and other staff members in seminars such as “Better Ways of Breaking Diagnostic News”, “The Modern Art of Caring for Families”, and “The Heart of Family-Centered Care”.

This model was so successful that after four years, Kaiser Permanente decided to fund the program when the SPRANS grant was complete. Parents reported satisfaction with the services that were offered by Kaiser Permanente and PHP. Efforts to replicate this successful model at two other managed care facilities began in 1998 through a grant funded by the HRSA Maternal and Child Health Bureau (MCHB). This grant, which ended in June 2002, allowed PHP to partner with Good Samaritan Hospital, a private managed care organization, and Valley Medical Hospital, a government-run hospital, to enhance family-centered, culturally competent care. At the time of this presentation, negotiations for continued funding through Good Samaritan and Valley Medical Hospitals were on-going. Plans to replicate this model with other hospitals in the San Francisco Bay Area are currently being explored.

Experiences with the PHP/Kaiser Permanente project provided several important lessons. First, it is crucial for community resource groups to build relationships with the managed care organizations serving the group’s members. Establishing trust and mutual respect through open communication is key, and can be facilitated by identifying “champions” within the managed care system. Secondly, a referral system that works for both entities is an important component for success. Establishing an Advisory Board composed of representatives from the managed care organization and the parent organization helps ensure that the goals and needs of both groups are met. Further, reliable technology and support for gathering quantitative and qualitative data is necessary to show improved outcomes in terms of health and/or patient satisfaction as well as cost-effectiveness. These lessons will provide the framework for potential models in the future.

Addressing Cultural and Linguistic Diversity in the Community Health Center Environment: The Sunset Park Family Health Center Network

Molly McNees, Ph.D.

Staff Medical Anthropologist

Sunset Park Family Health Center Network

Brooklyn, New York

Molly McNees, Ph.D. spoke to the group about Sunset Park Family Health Center (SPFHC) Network, a group of Federally-funded community health centers in and around Brooklyn, New York. The Network grew out of a single community health center established in 1967. The original OEO Neighborhood Health Center was based upon the Community Oriented Primary Care Model and has maintained a long tradition of assuring quality care by measuring clinical outcomes since 1990. Today, the vision of Sunset Park Family Health Center Network is to improve the overall health and well-being of the communities served by delivering high quality, culturally-competent primary care and related services within community-based settings.

The outcomes for which Sunset Park strives are three-fold:

- **Quality services that are competitive in a managed care environment**
- **Highly satisfied patients with improved health and well being**
- **High levels of staff satisfaction**

The communities that SPFHC Network cares for are generally medically underserved. In terms of insurance, 30 percent are enrolled in Medicaid, 25 percent in managed care, while 13 percent have private insurance, and 10 percent are covered by Medicare. A full 22 percent of SPFHC Network patients are uninsured. The patients reside in an urban, inner city environment. Seventy-eight percent live below 125 percent of the Federal poverty level. Twenty-five percent of patients (or 123,000) lost their Medicaid eligibility in Manhattan and now seek treatment in Brooklyn. Nearly 700,000 are uninsured Brooklyn residents.

The current SPFHC Network consists of 8 primary care centers, over 20 community and provider partnerships, and 13 school-based centers. Patient membership exceeds 90,000

users who make more than 575,000 annual visits. The ethnic mix of SPFHC Network closely reflects the communities it serves; 55 percent of patients are Hispanic, 12 percent Asian and Pacific Islander, 7 percent African American, and 26 percent white. With a high immigrant population, 40 percent of patients are limited English speakers. The SPFHC Network has several facilities that primarily serve patients of specific backgrounds based on the neighborhood composition.

For example, the Family Physician Health Center, one of the eight Sunset Park centers, mainly cares for Hispanic patients because it is geographically located in a mostly Hispanic neighborhood. Similarly, the Park Ridge Family Health Center offers multi-ethnic outreach and provides an Islamic prayer room, fish tanks (which are an Asian sign of good health) and complementary medicine services. There is also a Caribbean American Family Health Center in the Network. The SPFHC Network has also begun an Asian Initiative, which includes community partnerships and a needs assessment. Language access has been addressed by creating more culturally appropriate signage and translating written material. Staff development, including in-service training to staff, a new culturally competent hiring policy, and foreign nurse training, is another component of the Asian Initiative. The New Brooklyn Chinese Family Health Center is the primary care site for Brooklyn's Chinese community. Network-wide language access strategies have also been instituted, addressing patients who speak English, Spanish, Chinese dialects, Arabic, Russian, Haitian, and Creole.

In addition, SPFHC offers residency for new physicians training with a curriculum in cross-cultural health care. Integrated with Family Practice Residencies, this didactic and experiential curriculum teaches communication skills, such as patient-centered interviewing and medical anthropology. SPFHC Network is also engaged in research related to cultural competency. The Mexican Health Project, conducted in conjunction with Barnard College at Columbia University, is a multi-method study examining health issues and disparities in the Hispanic communities. Areas of focus are healthcare needs and experiences, reproductive expectations and experiences, folk medicine and self-care, and diabetes management. Study methods

SPFHC offers residency for new physicians training with a curriculum in cross-cultural health care.

include a cross-sectional survey, intensive patient interviews, ethnography, and focus groups. This study is supported by United Hospital Fund, CAP and HRSA Disaster Assistance.

Dr. McNees concluded her presentation by stating that SPFHC Network will continue its mission to enhance culturally competent care in order to meet new State and Federal mandates, tap new patient markets, achieve quality and satisfaction for patients and staff, and improve clinical outcomes.

Project Street Beat, PPNYC

Daphne Hazel

Associate Vice-President

*Project Streetbeat, Planned Parenthood of New York City
Bronx, New York*

HIV and AIDS are a serious threat to the underserved, culturally diverse community living on the streets of Bronx, New York. Daphne Hazel, Associate Vice-President of Project Street Beat, described this program from Planned Parenthood that tackles HIV/AIDS on its own turf. Project Street Beat's mission is to reduce the rate of HIV transmission by empowering communities of color and others to change risk behaviors and to receive HIV care-related services. The uniqueness of Project Street Beat is that treatment, education, and outreach are delivered straight to the streets of the South Bronx where teens and young adults are at greatest risk.

Project Street Beat started in 1988 in the South Bronx, but now includes consolidated services in Brooklyn, Queens, Bedford, and Northern Manhattan. The individuals served through Project Street Beat are predominantly black (55%) or Latino (43%); the ratio of males to females is nearly equivalent. Thirty-percent of patients are between the ages of 14 and 25, with 69% age 25 and older. The target population is at high risk for HIV/AIDS because of the nature of their activities: 8% are commercial sex workers, 52% use intravenous drugs or other substances, 30% are adolescents, and 6% are other "hard-to-reach" populations including men who have sex with men, transgender or transsexual individuals, or parolees.

The concept behind Project Street Beat is for an outreach team to establish a presence on the street and offer practical help on the spot. The outreach teams build relationships with clients based on trust and develop a rapport with clients' allies, who may include pimps, drug dealers, abusive partners, family, and friends. Gaining the support of allies is essential because they can be influential in promoting or negating the healthy practices Project Street Beat teaches.

The Outreach Teams explore the target areas to identify the "hot spots", areas where drug dealing or sex peddling occurs. Once there, the teams conduct impromptu "focus groups" by engaging potential clients in conversation about what Project Street Beat is all about. The teams continue to cultivate the areas by repeatedly visiting and establishing a familiar presence. Van Outreach and Mobile Medical Unit Outreach offer various levels of care from oral HIV testing to gynecological exams and birth control.

Project Street Beat is built on the premise that culture is not limited to race and ethnicity; rather, it includes customary beliefs, shared attitudes, values, practices, and integrated patterns of behaviors. The staff reflects the racial and ethnic make-up of the target population with 18 African-American staffers and 12 Latino staff members. They also have employees who speak English, various Spanish dialects, and Creole. The staff is diverse in their ages, life experiences, sexual orientation, and professional backgrounds. Project Street Beat also hires Peer Educators who are former drug abusers or sex workers living with HIV.

Project Street Beat is built on the premise that culture is not limited to race and ethnicity; rather, it includes customary beliefs, shared attitudes, values, practices, and integrated patterns of behaviors.

Applying cultural competence in this environment means understanding the clients' needs and motivations. For example, because sex is currency in the drug economy of the street, using a condom can mean making less money or putting oneself at risk for violence. For this reason, outreach strategies must be creative, such as gaining the acceptance of a client's pimp or abusive partner or by making arrangements to meet the client in a safe place. With adolescents who are often outcast from troubled families and who are wary and rebellious, cultural competence means understanding that these clients

may not trust adults. In these cases, outreach may include gaining the trust of a leader in the group whom other teens tend to follow.

Project Street Beat does not act alone; the group collaborates with numerous community agencies to meet their clients' needs. These collaborators include AIDS centers and hospitals, detoxification centers, drug rehabilitation centers, substance abuse programs, community health centers, maternal/child centers, legal and social services, housing, food banks, faith-based organizations, and other community-based organizations.

Project Street Beat's 14-year history is a testament to its success, as are some of its more recent accomplishments. In 2001, Project Street Beat made a difference in the lives of many people living and working on the streets of New York City, as the following figures reveal:

Project Street Beat Accomplishments in 2001:

- Served 24,295 people in need of care
- 4,053 harm reduction counseling sessions
- 1,349 HIV tests
- 719 post-test HIV counseling
- 479 medical exams
- 4,476 referrals
- 422 case management clients
- 240 support groups and presentations to community based organizations

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PLENARY SESSION: An Interactive Session Opportunity to Discuss Challenges in Delivering Culturally and Linguistically Competent Health Care

The day-long program culminated in a plenary session during which three panelists (Felicia Batts, Josepha Campinha-Bacote, and Calvin Freeman) addressed challenging areas identified by the audience that can arise when developing culturally and linguistically appropriate services and programs. In an interactive session, these expert

facilitators led a discussion on approaches that can be used to address those issues raised by the audience. The audience provided questions, and panelists facilitated a discussion to provide answers. The questions and resultant group answers are summarized in this section.

1. Please comment on strengths/weaknesses of implementing cultural competence initiative through a Quality Improvement (QI) committee.

For managed care organizations, QI committees are a logical place to introduce cultural competency initiatives because these committees have a broad influence on what happens in the whole organization and because QI committees focus on measurement and outcomes, so initiatives would more likely be assessed to show an actual impact on patient care or organizational processes. Also, implementing cultural competency through QI guarantees that the high-level executives at the hospital or MCO will be included in these initiatives.

The California Department of Health Services (CDHS) is an excellent resource for community-based groups looking for information in this area; CDHS has developed policy letters that address how to develop a cultural competency quality improvement initiative. Importantly, access to accurate racial and ethnic data will be crucial to the success of QI projects. Health plans may be able to get this type of data through collaboration with state agencies.

2. As a coordinator of a Substance Abuse and Mental Health Services Administration grant focusing on mental health disparities in the Russian and Latino community, what are some suggestions you have for training to encourage cultural competence of primary care providers?

One overriding challenge in mental health is that psychiatric conditions are often viewed as not as important as diagnoses of physical conditions, such as diabetes or asthma, when in fact both types of conditions impact one another. This bias, combined with cultural competency challenges, poses a significant dilemma for mental health therapists and their clients. One participant suggested that medical

schools and residency programs are one arena in which to strive for improvements. Primary care and mental health specialists who can discuss cultural competency may be effective as consultants to introduce cultural competency early in medical education so as to instill new paradigms in the future healthcare professional community.

Another participant responded that in the rural area where she works, cultural competency issues are not well understood or accepted by veteran physicians, and finding a cultural competency consultant is difficult. The HRSA Managed Care and Health Services Financing Technical Assistance Center is one resource for providing such training. Offering Continuing Medical Education (CME) credits in cultural competency will also draw physicians of all ages to attend training sessions. Ms. Batts commented that many physicians need CME credits specifically in the category of ethics, so as ethics-oriented CME programs are developed, there needs to be greater focus on cultural competency.

3. What is the difference between Hispanic and Latino? Is one more culturally sensitive or correct? Does one encompass all people of Spanish descent?

There was no consensus on this issue. The terms 'Chicano', 'Hispanic', and 'Latino' were discussed. Though 'Chicano' is used rarely now, the difference between the other terms was less clear. The preferred term may vary by region and by individual. It is best to know the general preference of community you serve, but to accept that from patient to patient, attitudes may differ. Self-definition should be respected. More importantly, if patients know that their providers care about and respect them, the political correctness of terms used will most likely not be challenged.

4. Are certain diseases found more frequently among particular ethnic populations? What common misdiagnoses exist according to ethnicity?

Cultural competency is not just about values, beliefs and attitudes; there are biological and clinical issues that are relevant. But there is still considerable controversy about whether widespread genetic variation exists among ethnic and

racial groups. It is well-established that certain diseases are more prevalent in certain groups. One participant expressed concern about misdiagnosis of these diseases. Certain “cultural-bound illnesses”, particularly in the mental health arena, are an example. Dr. Campinha-Bacote stated that there is national evidence that people of color are more often misdiagnosed with thought-disorders, such as schizophrenia, whereas whites are more often diagnosed or misdiagnosed with mood disorders, such as depression. In addition, another participant emphasized that it is important for providers to be aware of diseases that may be truly be more prevalent in particular populations, for instance, diabetes in the Latino population.

5. **As a Healthy Start grantee, we provide trained medical interpreters to providers. Demand for interpreter services exceeds our resources, yet providers say they cannot pay for services on a contracted basis. How can Massachusetts’ funds be tapped to reimburse for interpreter services?**

The panelists and meeting participants offered several options. Approaching the legislature for Title IV funds was one approach suggested. Also, community-based resources may be available, and community agencies receiving State and Federal funds are mandated to assist in the area of translator services. Finally, be creative about partnerships and alternate funding sources.

Other Comments:

1. Sonja Boone, MD, from Northwestern Memorial Hospital commented that to enhance the awareness and use of the language line, her hospital had speaker-phones installed in the emergency rooms and clinical units. In addition, they developed a formal program for minority physician recruitment.
2. The group identified the literacy level and legalese in informing documents as another challenge to culturally competent services. Readability of language and visual presentation can limit communication to consumers. Colors, font size, white space, graphics, and grade level of textual material should always be considered and revised if necessary.

